RESPONSIBLE PARTY-DIRECTED LINE THERAPY SERVICES LIABILITY STATEMENT/PDD STATE FUNDED PROGRAM

Child's Name: _____

In connection with my use of Line Therapy services provided through the PDD State Funded Program, I acknowledge that I have been informed, and understand, the following:

1. **LINE THERAPISTS ARE EMPLOYED BY THE Responsible Party (RP).** Line Therapists do not work for the Community Long Term Care (CLTC), the South Carolina Department of Health and Human Services (DHHS), the Department of Disabilities and Special Needs (DDSN), the Jasper County Board of Disabilities and Special Needs or any other state or local agency, and are not authorized to speak or act on behalf of any of these organizations.

2. Neither CLTC, DHHS, DDSN, JCBDSN nor any other state or local agency is responsible for the acts or omissions of Line Therapists.

3. Under South Carolina law, if the RP employs four or more Line Therapists providers, the RP is required to get a workers compensation policy at the RP's expense.

4. Line Therapists are not provided with any liability insurance coverage or benefits by, are not bonded by, and are not licensed by CLTC, DHHS, DDSN, JCBDSN or any other state or local agency.

5. Injury to the Line Therapist or to the child is not the responsibility of CLTC, DHHS, DDSN, JCBDSN or any other state or local agency.

6. As a health care provider and Line Therapist I understand that I must abide by all HIPAA rules and regulations and keep all health information confidential.

7. As a health care provider and Line Therapist, I understand I am required to report any suspected abuse neglect or exploitation of the child to the local County Department of Social Services and the child's Service Coordinator.

8. Use of a specific Line Therapist is the **RP's choice.** As the Line Therapist, I understand it is standard practice to give 2 weeks notice unless I fear for my personal safety.

9. As the RP, my signature on this statement confirms that the Line Therapist I have chosen is not a legal guardian for me/the child and is not the Health Care POA for me/the child.

10. As the RP, my signature on this statement authorizes the release of any medical or other information necessary to process PDD State Funded Program claims on my behalf. I request payment of PDD State Funded Program benefits to this party who provides services as a PDD State Funded Program services provider and agrees to accept the approved rate of reimbursement from Jasper County DSN Board.

_____ _____

Date Responsible Party Signature

_____ _____

Date Line Therapist Signature

_____ Line Therapist _____Responsible Party _____JCBDSN